This analysis form should be read in conjunction with the collated reporting form, and the PMRT in babies who die on a neonatal unit, delivery suite or labour ward, to provide relevant information on the child, the circumstances of their death, and factors identified in any of the relevant domains.

**Using this form at the Child Death Review meeting**

Information gathered from the different agencies should be made available to the Child Death Review meeting by the relevant CDOP administrator. Drawing on the intelligence gathered, those present at the child death review meeting should then appraise all the relevant information in order to form an understanding of the circumstances of the child’s death, identify any modifiable factors and lessons to be learnt, and any action that will be taken at a local level. The completed Analysis form from the Child Death Review meeting should then be submitted to the CDOP.

**Using this form at the Child Death Overview Panel meeting**

The completed form from the Child Death Review meeting, along with any additional information gained from other agency sources should be presented in anonymised form to the CDOP. Drawing on the intelligence gathered, those present at the CDOP should appraise the relevant information in order to affirm that the understanding of the circumstances of the child’s death is correct, that appropriate modifiable factors and lessons have been identified, and decide upon any actions to be taken across agencies or networks of care

**Child Death Review Meeting date:**  / /

**CDOP Meeting date:**    /    /

**Individuals/ Departments/ agencies represented\* at CDR meeting / CDOP:**

|  |  |  |
| --- | --- | --- |
| ☐ Admin or Clerical | ☐ Mental Health Services | ☐ Primary Health Care |
| ☐ Ambulance Services | ☐ Midwifery | ☐ Risk Manager or  Governance Team |
| ☐ Bereavement Team | ☐ Neonatal Nurse | ☐ Safety Champion |
| ☐ Children's Social Care  Services | ☐ Neonatology | ☐ Schools |
| ☐ External | ☐ Obstetrics | ☐ Hospital Services |
| ☐ Paediatrics | ☐ Management Team | ☐ Police |
| ☐ Public Health | ☐ Palliative Care Services | ☐ CCG |
| ☐ LeDeR | ☐ Other (please specify) | |

***\* Including reports submitted by professionals and agencies unable to attend meeting in person***

**Additional agency reports provided for purposes of CDOP review:**

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The review meeting should analyse any relevant factors that may have contributed to the child’s death. In doing so you might take into account those issues that have been highlighted in the Reporting Form. For each of the four domains below, list the factor, and determine the level of influence (0-2):

0 - Information not available

1 - No factors identified, or factors identified but are unlikely to have contributed to the death

2 - Factors identified that may have contributed to vulnerability, ill health or death

This information should inform the learning of lessons at a local level.

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| ***Domain A:* Factors intrinsic to the child.** Please list factors in the child (and in neonatal deaths, in the pregnancy). Consider factors relating to the child’s age, gender and ethnicity; any pre-existing medical conditions, developmental or behavioural issues or disability, and for neonatal deaths, the mother’s health and wellbeing. | | | | |
|  | | | **CDOP affirmation** | |
| **Factor** | **Relevance**  **(0-2)** | **Is this factor deemed to be modifiable?** | **Relevance**  **(0-2)** | **Is this factor deemed by CDOP to be modifiable?** |
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| ***Domain B:* Factors in social environment including family and parenting capacity.** Please list factors in family structure and functioning and any wider family health issues; provision of basic care (safety, emotional warmth; stimulation; guidance and boundaries; stability); engagement with health services (including antenatal care where relevant); employment and income; social integration and support; nursery/preschool or school environment. | | | | |
|  | | | **CDOP affirmation** | |
| **Factor** | **Relevance**  **(0-2)** | **Is this factor deemed to be modifiable?** | **Relevance**  **(0-2)** | **Is this factor deemed by CDOP to be modifiable?** |
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| Please also describe positive aspects of social environment and give detail to examples of excellent care | | | | |

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| ***Domain C:* Factors in the physical environment.** Please list issues relatingto the physical environment the child was in at the time of the event leading to death, and for neonatal deaths, the mother’s environment during pregnancy. Include poor quality housing; overcrowding; environmental conditions; home or neighbourhood safety; as well as known hazards contributing to common childhood injuries (e.g. burns, falls, road traffic collisions). | | | | |
|  | | | **CDOP affirmation** | |
| **Factor** | **Relevance**  **(0-2)** | **Is this factor deemed to be modifiable?** | **Relevance**  **(0-2)** | **Is this factor deemed by CDOP to be modifiable?** |
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| ***Domain D:* Factors in service provision.** Please list any issues in relation to service provision or uptake. Include any issues relating to identification of illness, assessment, investigations and diagnosis; treatment or healthcare management; communication or teamwork within or between agencies; and organisational or systemic issues. Consider underlying staff factors, task factors, equipment, and work environment, education and training, and team factors. | | | | |
|  | | | **CDOP affirmation** | |
| **Factor** | **Relevance**  **(0-2)** | **Is this factor deemed to be modifiable?** | **Relevance**  **(0-2)** | **Is this factor deemed by CDOP to be modifiable?** |
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| Please also describe positive aspects of service delivery and give detail to examples of excellent care | | | | |

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| **Consider whether the Review has identified one or more factors across any domain which may have contributed to the death of the child and which might, by means of a locally or nationally achievable intervention, be modified to reduce the risk of future child deaths** | **CDR Review** | **CDOP**  **affirmation** |
| **Modifiable factors identified – please list these below *(****Please also ensure these factors are listed under each domain and are indicated as modifiable)* | ☐ | ☐ |
| **No modifiable factors identified** | ☐ | ☐ |
| **Inadequate information upon which to make a judgement.**  *NB this category should be used very rarely indeed.* | ☐ | ☐ |
| List of modifiable factors identified: | | |

**In light of your consideration of the case categorise the likely cause of death using the following schema.**

This classification is hierarchical. **All relevant categories should be ticked if more than one category could reasonably be applied**. The uppermost ticked category will be recorded as the primary category and others as secondary categories.

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| **Category** | **Name & description of category** | **Tick box below** | **CDOP**  **affirmation** |
| 1 | **Deliberately inflicted injury, abuse or neglect** This includes suffocation, shaking injury, knifing, shooting, poisoning & other means of probable or definite homicide; also deaths from war, terrorism or other mass violence; includes severe neglect leading to death. | ☐ | ☐ |
| 2 | **Suicide or deliberate self-inflicted harm**  This includes hanging, shooting, self-poisoning with paracetamol, death by self-asphyxia, from solvent inhalation, alcohol or drug abuse, or other form of self-harm. It will usually apply to adolescents rather than younger children.  **Please choose from the sub-categories below:** | | |
| 2 (i) | **Suicide (where the panel feels the intention of the child was to take their own life)** | ☐ | ☐ |
| 2 (ii) | **Self-inflicted harm leading to death (where it is unclear if the child's intention was to take their own life)** | ☐ | ☐ |
| 2 (iii) | **Death as the result of substance misuse (excluding deaths as a result of a deliberate overdose)** | ☐ | ☐ |
| 3 | **Trauma and other external factors, including medical/surgical complications/error**  This includes isolated head injury, other or multiple trauma, burn injury, drowning, unintentional self-poisoning in pre-school children, anaphylaxis & other extrinsic factors. Also includes proven medical and surgical complications or errors as the primary cause of death. **Excludes** Deliberately inflicted injury, abuse or neglect (category 1). | ☐ | ☐ |
| 4 | **Malignancy** Solid tumours, leukaemias & lymphomas, and malignant proliferative conditions such as histiocytosis, even if the final event leading to death was infection, haemorrhage etc. | ☐ | ☐ |
| 5 | **Acute medical or surgical condition**  For example, Kawasaki disease, acute nephritis, intestinal volvulus, diabetic ketoacidosis, acute asthma, intussusception, appendicitis; sudden unexpected deaths with epilepsy. | ☐ | ☐ |
| 6 | **Chronic medical condition**  For example, Crohn’s disease, liver disease, immune deficiencies, even if the final event leading to death was infection, haemorrhage etc. **Includes** cerebral palsy with clear post-perinatal cause. | ☐ | ☐ |
| 7 | **Chromosomal, genetic and congenital anomalies**  Trisomies, other chromosomal disorders, single gene defects, neurodegenerative disease, cystic fibrosis, and other congenital anomalies including cardiac. | ☐ | ☐ |
| 8 | **Perinatal/neonatal event**  Death ultimately related to perinatal events, e.g. sequelae of prematurity, antepartum and intrapartum anoxia, bronchopulmonary dysplasia, necrotising enterocolitis, post-haemorrhagic hydrocephalus, irrespective of age at death. It **includes** cerebral palsy without evidence of cause, and **includes** congenital or early-onset bacterial infection (onset in the first postnatal week).  **Please choose from the sub-categories below:** | | |
| 8 (i) | **Immaturity/Prematurity related** | ☐ | ☐ |
| 8 (ii) | **Perinatal Asphyxia (HIE and/or multi-organ failure)** | ☐ | ☐ |
| 8 (iii) | **Perinatally acquired infection** | ☐ | ☐ |
| 8 (iv) | **Other (please specify)** | ☐ | ☐ |
| 9 | **Infection**  Any primary infection (i.e. not a complication of one of the above categories), arising after the first postnatal week, or after discharge of a preterm baby. This would include septicaemia, pneumonia, meningitis, HIV infection etc. | ☐ | ☐ |
| 10 | **Sudden unexpected, unexplained death** Where the pathological diagnosis is either ‘SIDS’ or ‘unascertained’, at any age. **Excludes** Sudden Unexpected Death in Epilepsy (category 5). | ☐ | ☐ |

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| **Cause of death:**  In light of your review of this case, what is your opinion as to the likely cause/causes of death? Please indicate if this differs in any way from the registered cause of death or that assigned by the pathologist/coroner. Where possible, please express this in terms of the levels provided on the Medical Certificate of Cause of Death (MCCD) /neonatal MCCD. |

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| **Learning points and issues identified in the review:** |
| List the learning points identified by the review group. A list of issues may include the absence of certain key persons from the discussion or the lack of key documents. |
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| **CDOP affirmation and reflection on learning points pertaining to wider agency, regional, and national bodies.** |

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| Did the panel identify any specific issues following the review of the death for immediate national alert and action that should be highlighted to NCMD? If yes, please specify: |

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| **Actions:**  Identify any local actions, the department or agency responsible, and the timeline to completion. This should include those interventions deemed achievable that determined contributory factor to be modifiable. |
| **CDOP affirmation:**  Identify any CDOP actions and/or recommendations at an agency, LSCB, regional or national level. This should include those interventions deemed achievable that determined contributory factor to be modifiable. |

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| **Summary of ongoing support needs and follow-up plans for the family and (where relevant) involved professionals** |