**EXAMPLE TEMPLATE: Plan to meet the requirements of Working Together 2018 and the Child Death Review Statutory and Operational Guidance**

**PLEASE NOTE: IT IS NOT MANDATORY THAT YOU SUBMIT YOUR PLANS IN THIS FORMAT, THIS TEMPLATE HAS BEEN CREATED AS A GUIDE AND EXAMPLE OF HOW TO ENSURE YOU COMPLY WITH THE CDR EXTENDED GUIDANCE**

In July 2018 a revised version of [Working Together to Safeguard Children](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/779401/Working_Together_to_Safeguard-Children.pdf) was published. In October 2018 they published an additional document for the child death review process entitled “[Child Death Review Statutory and Operational Guidance](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/777955/Child_death_review_statutory_and_operational_guidance_England.pdf)” (referred to hereafter as Operational Guidance). These two statutory documents lay out in detail the processes that must be followed when a child dies. There is also [Transitional guidance](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/722306/Working_Together-transitional_guidance.pdf) that accompanies Working Together.

This guidance requires Child Death Review Partners (Clinical Commissioning Groups and Local Authorities) to agree and publish their new arrangements for child death reviews by 29th June 2019. They should notify NHSE of the new arrangements by emailing england.cypalignment@nhs.net by that date. Following the submission of the plan for their new arrangements, CDR partners then have until 29th September 2019 to implement their new arrangements.

The following template is intended as a guide for CDR partners to use to submit details of their arrangements for child death reviews.

**Section 1: Contact Details of Child Death Review Partners**

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| **Names of Child Death Review Partners***This section should include details of ALL the child death review partners for your area. Please add more rows if needed.* |
| Name of organisation |  | [ ]  Clinical Commissioning Group[ ]  Local Authority |
| Name of contact for child death reviews within organisation |  |
| Email address of contact |  |
| Telephone number of contact |  |
| Name of organisation |  | [ ]  Clinical Commissioning Group[ ]  Local Authority |
| Name of contact for child death reviews within organisation |  |
| Email address of contact |  |
| Telephone number of contact |  |
| Please indicate the lead CDR partner *(NB: this must be one of the organisations listed above)* |  |
| Please indicate which CDR partner(s) are responsible for commissioning the new arrangements if different from above |  |

**Section 2: Details of Child Death Overview Panel (CDOP or equivalent structure, hence referred to as CDOP).**

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| **Details of CDOP or equivalent***This section should include details of the area covered by your CDOP* |
| Name of CDOP |  |
| Name of CDOP Manager / Administrator |  |
| Email address of CDOP |  |
| Telephone number of CDOP |  |
| Please list ALL the local authority areas covered by your CDOP |  |
| Number of deaths reviewed in total in the 2018/19 year in the areas listed above |  |

**Section 3: Requirements of Working Together to Safeguard Children 2018 and the Child Death Review Statutory and Operational Guidance.**

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| **Requirement WT1: To make arrangements to review the deaths of children normally resident in the local area (including if they die overseas) and, if they consider it appropriate, for any non-resident child who has died in the area** |
| **Q1.1 Please give an overview of your local arrangements for reviewing child deaths.** *This should include details of the administrative and logistical processes and should give details of the local arrangements for the notification process, information gathering, child death review meetings, frequency of CDOP meetings*  |
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| **Q1.2 Please describe the process that will be followed when a child not resident in your area dies in your area.** *This should include how the CDOP in the area of residence will be notified, how decisions will be made about who conducts the review and retains responsibility for the case.*  |
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| **Q1.3 Please describe how you will engage with hospitals in your area to ensure good communication and sharing of information when a child dies.** *This should include consideration of the notification process, completion of reporting forms and supplementary reporting forms, and whether you support arrangements for child death review meetings through provision of agency reporting forms* |
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| **Requirement WT2: To make arrangements for the analysis of information from all deaths reviewed** |
| **Q2.1 National analysis of information from deaths reviewed will be undertaken by NCMD, and there is a statutory duty to provide data to NCMD for this purpose. Please describe how you will provide information to NCMD**. *This should include details of how you submit data to NCMD securely and details of any other local analysis you plan to undertake* |
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| **Requirement WT3: At such times as are considered appropriate, prepare and publish reports on what you have done as a result of the child death review arrangements in your area, and how effective the arrangements have been in practice** |
| **Q3.1 Please describe your plans for publication of reports related to this requirement.** *This should include details of what reports you plan to publish (if appropriate) and where they will be published* |
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| **Requirement WT4: To consider the core representation of your CDOP (or equivalent)** |
| **Q4.1 Please give details of the agencies and job roles of the individuals on your CDOP.** *This should include details of core members and any members that are co-opted for specific discussions / themed panel meetings* |
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| **Requirement WT5: To appoint a Designated Doctor for Child Deaths. This should be a senior paediatrician who can take a lead in the review process, and to ensure the Designated Doctor for Child Deaths is notified of each child death and sent relevant information** |
| **Q5.1 Please give details of this role in your local area.** *This should include which organisation the role is employed within and the number of working hours for the post. Please also include a job description if available.* |
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| **Q5.2 Please describe the process for notifying the Designated Doctor for Child Deaths when a death occurs.** *This should include details of who is responsible for carrying out the notification and how this occurs (e.g. email / telephone via the CDOP admin team).*  |
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| **Requirement WT6: Publicise information on the arrangements for child death reviews in your area.**  |
| **Q6.1 Please give details on where the information for child death reviews in your area can be publicly accessed.** *The information publicly available should include who the accountable officials are (the local authority chief executive and the accountable officer of the clinical commissioning group), which local authority and clinical commissioning group partners are involved, what geographical area is covered and who the designated doctor for child deaths is* |
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| **Requirement WT7: Child death review partners should agree locally how the child death review process will be funded in their area.** |
| **Q7.1**. **Please give details on how the CDR process in your area is being funded?** *This might include mention of funding coming from LA, CCG and Health Care Trusts.* |
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**Section 4: Requirements of the Child Death Review Statutory and Operational Guidance**

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| **Requirement OG1: Chief Executives of clinical commissioning groups (CCGs) and local authorities should ensure that all of their staff who are involved in the child death review process read and follow the operational guidance.**  |
| **Q1.1 Please describe how you have ensured that all staff within the child death review process have read and follow the operational guidance**. This should include methods of dissemination of the guidance and any training / awareness raising sessions that have been provided |
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| **Requirement OG2: Families should be given a single, named point of contact, the “key worker”, for information on the processes following their child's death, and who can signpost them to sources of support.** |
| **Q2.1 Please describe your process for assuring that relevant organisations have appointed a key worker in the event of a child death.** *This should include details of the responsibilities of that post* |
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| **Requirement OG3: To report deaths of children with learning disabilities or suspected learning disabilities to the Learning Disabilities Mortality Review Programme (LEDER).** |
| **Q3.1 Please describe your process for notifying LEDER of the death of a child with a learning disability.** *This should include details of who is responsible for making the notification and how it occurs (e.g. telephone / email)*  |
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| **Requirement OG4: A Joint Agency Response (JAR) should be considered if certain criteria, set out in the guidance are met.** |
| **Q4.1 Please describe your model for JAR.** *This should include details of who the lead health professional will be (e.g. nurse / health visitor / paediatrician), details of who attends when a home visit is required and the times between which the JAR is available e.g. is there an on-call element? Please also include details of the estimated number of deaths requiring a JAR in your area each year.*  |
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| **Requirement OG5: Conduct a child death review meeting for every child** |
| **Q5.1 Please describe how the child death review meeting will be convened for the following groups:*** **Children who die in hospitals in your area**
* **Neonatal deaths in hospitals in your area (this should include use of the Perinatal Mortality Review Tool (PMRT)**
* **Children who die in the community in your area**
* **Children whose deaths trigger a joint agency response**
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| **Requirement OG6: Produce an annual report on local patterns and trends in child deaths, any lessons learnt, and actions taken, and the effectiveness of the wider child death review process** |
| **Q6.1 Please give details of when you will produce your annual report and where it will be published** |
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