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 was published. In October 2018 they published an additional document for the child death review process entitled "Child Death Review Statutory and Operational Guidance" (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 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

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	London Borough of Bromley	☐ Clinical Commissioning Group ☐ Local Authority
Name of contact for child death reviews within organisation	Dr Jenny Selway	
Email address of contact	jenny.selway@bromley.gov.uk	
Telephone number of contact	020 8313 4769	
Name of organisation	Bromley Clinical Commissioning Group	☐ Clinical Commissioning Group ☐ Local Authority
Name of contact for child death reviews within organisation	Sonia Colwill	
Email address of contact	sonia.colwill@nhs.net	
Telephone number of contact	020 3930 0104	
Please indicate the lead CDR partner *(NB: this must be one of the organisations listed above)*	London Borough of Bromley	

Please indicate which CDR partner(s) are responsible for commissioning the new arrangements if different from above	

Name of organisation	London Borough of Southwark & London Borough of Lambeth	☐ Local Authority
Name of contact for child death reviews within organisation	Kirsten Watters	
Email address of contact	kirsten.watters@southwark.gov.uk	
Telephone number of contact	020 7525 7758	
Name of organisation	Southwark Council	Local Authority
Name of contact for child death reviews within organisation	Helen Turnage	
Email address of contact	helen.turnage@southwark.gov.uk	
Telephone number of contact	0207 525 3105	
Please indicate the lead CDR partner *(NB: this must be one of the organisations listed above)*	London Borough of Southwark	

Please indicate which CDR partner(s) are responsible for commissioning the new

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

Details of CDOP or equivalent *This section should include details of the area covered by your CDOP*	
Name of CDOP	Bromley, Lambeth and Southwark CDOP
Name of CDOP Manager / Administrator	Hazel Blackman (Bromley) Helen Turnage (Southwark & Lambeth)
Email address of CDOP	CDOP@bromley.gov.uk CDOP@Southwark.gov.uk (for Southwark & Lambeth notifications)
Telephone number of CDOP	020 8461 7816 (Bromley) 0207 525 3105 (Southwark & Lambeth)
Please list ALL the local authority areas covered by your CDOP	Bromley, Lambeth, Southwark
Number of deaths reviewed in total in the 2018/19 year in the areas listed above	56 (average usually nearer 70 deaths)

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

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*
1. The current arrangements for notification will remain unchanged. There will be a single SPOC for Lambeth and Southwark with 1 WTE administrator, and a separate SPOC for Bromley with 0.6WTE administrator (part of a team with appropriate cover). There will also be 1WTE Process Manager in Lambeth and Southwark, and 0.5 Child Death Nurse/Process Manager in Bromley. 2. The Designated Doctor for Child Deaths will be notified about child deaths in their borough (1.5PA Community Paediatrician in each borough) and liaise with the Lead Paediatrician in decisions about whether a JAR is required. 3. Where a JAR does take place the Designated Doctor for that borough will chair the meeting. When the Designated Doctor is not available another Community Paediatrician from their borough team will attend the meeting in their place and liaise with the Designated Doctor as soon as practicable. 4. The Designated Doctors will attend CDRMs for out of hospital deaths or if there has been a JAR. The Designated Doctor will attend all CDOPs on a rota basis. 5. All non-neonatal deaths will be processed and reviewed by the Lambeth and Southwark Child Death team. All neonatal deaths will be processed and reviewed by the Bromley Child Death team. Members of each Child Death team will attend the CDOP meetings as appropriate. 6. A CDOP to review all non-neonatal deaths will be chaired by the current Lambeth and Southwark CDOP chair every two months. A CDOP to review all neonatal deaths will be chaired by the current Bromley CDOP chair every two months. The chairs will cover for each other in case of leave, illness etc. 7. Police, Children's Social Care and other key members of the CDOP will be asked to liaise with colleagues in the other boroughs so that, in general, only 1 representative from each key agency attends each CDRM and CDOP.
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.*
This will follow current procedure, where this is discussed by CDOP process managers and Designated Doctors between the two CDOP areas. In the majority of cases this will occur when a child dies in a NICU or PICU. As most children in Bromley, Lambeth and Southwark will die in one of the tertiary units in this CDOP area, this will be managed with the proposed Bromley, Lambeth and Southwark arrangements and be led by the Designated Doctor for the borough where the child is resident.
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*

1. Notification pathways are remaining unchanged in Bromley, Lambeth and Southwark.
2. Completion of reporting forms will be led by the relevant team (neonatal by Bromley, non-neonatal by Lambeth and Southwark), with support from the other Child Death team as required.
3. It is anticipated that the borough Child Death teams will support the CDRM process by provision of agency reporting forms initially. This will be kept under review as the provider units develop their capacity and expertise around the management of the CDRM process.

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*

1. Bromley, Lambeth and Southwark all use eCDOP, which automatically updates the NCMD.
2. In addition a South East London STP Child Death Steering Group has been set up which will review the data from Bromley, Lambeth and Southwark and Bexley, Greenwich and Lewisham joint CDOPs. This group will aim to share data and learning from child deaths, and take forward action at STP level where appropriate.

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*

1. It is planned to review the new arrangements in Q4 of 2019/20 in order to identify any challenges or learning from the new system and identify any cost pressures for 2020/21. A report on this review will be presented to the relevant Quality Committee in Bromley CCG and the Bromley SCB and shared with Child Death partners in Lambeth and Southwark. It is hoped to link this to a pan-London evaluation of the Child Death function in Q4 2019/20.
2. The Annual Report for Child Deaths will be produced in April 2020 and presented to all the Child Death partners in Bromley, Lambeth and Southwark.

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*

Non-neonatal CDOP
Consultant in Public Health Medicine, LB Southwark (Chair)
Designated Doctors for Child Death (2 of the 3 Designated Drs on a rota basis)
Process Manager for Child Death, LB Southwark and LB Lambeth (Joint post)
Administrator for Child Deaths, LB Southwark
Police representative (in liaison with Police from all 3 boroughs)
Children Social Care representative (in liaison with CSC from all 3 boroughs)
Children's Hospice representative (in liaison with Children's Hospices from all 3 boroughs)
Designated Nurse / Named Nurse / Safeguarding nurse
Acute Paediatrician

Other members may include CAMHS professionals, school representatives, GPs, HVs or School Nurses, Traffic Police, Coroners Officers.
Bromley representatives may attend the non-Neonatal CDOP for specific cases.

Neonatal CDOP (NDOP)
Consultant in Public Health Medicine, LB Bromley (Chair)
Designated Doctors for Child Death (1 of the 3 Designated Drs on a rota basis)
Child Death Nurse/Process Manager for Child Death, LB Bromley
Administrator for Child Deaths, LB Bromley
Police representative (in liaison with Police from all 3 boroughs)
Children Social Care representative (in liaison with CSC from all 3 boroughs)
Bereavement Midwife from each hospital trust
Consultant Obstetrician (in liaison with the Obstetric Child Death leads from each provider)
Consultant Neonatologist (in liaison with the Neonatal Paediatric Child Death leads from each provider)

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.*

Bromley. 1.5PA Community Paediatrician for Designated Doctor role (increased from 1.2Pas). Employed in Bromley Healthcare Community Interest Company (community provider)
Lambeth. 1.5PA Community Paediatrician for Designated Doctor role (increased from 1 PA). Employed by Guy's and St Thomas' Trust
Southwark. 1.5PA Community Paediatrician for Designated Doctor role (increased from 1 PA). Employed by Guy's and St Thomas' Trust

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).*

As now, the professional in charge of the child who dies is responsible for notifying the death. This happens via the SPOC in Bromley for Child Deaths (CDOP email address or telephone number). Once the CDOP is merged from September 2019, notifications will be either through the SPOC in Southwark (for Southwark and Lambeth notifications) or the SPOC in Bromley, who will both have access to eCDOP for all three boroughs.

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*

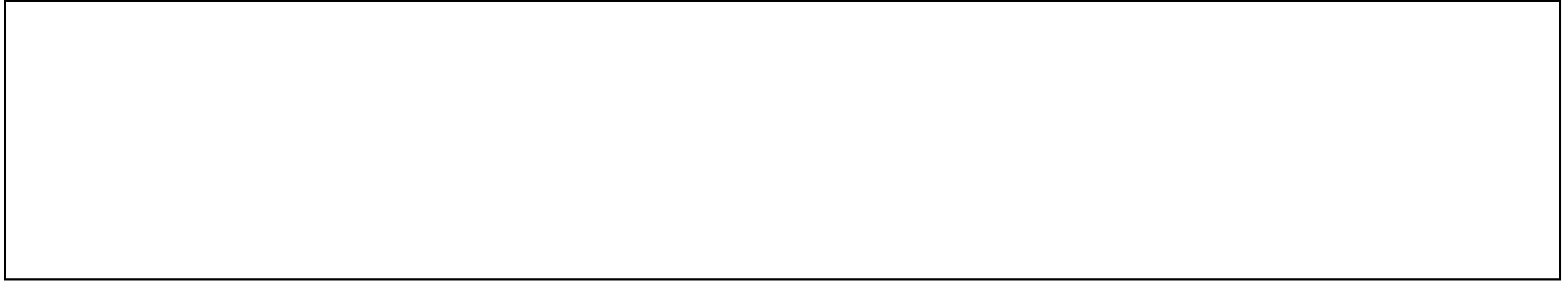
1. Via the BSCB, LSCB and SSCB (Children's Safeguarding Boards).

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.*

Bromley
1. The Designated Doctor and Nurse roles for Bromley are funded by Bromley CCG
2. The CDOP Chair is funded by LB Bromley
3. Additional costs for admin, additional CD Nurse and Process Manager will be divided equally between Bromley CCG and LB Bromley.

Southwark & Lambeth
1. The Designated Doctor and Nurse roles for Southwark & Lambeth are funded by Guys and St Thomas' Trust
2. The CDOP Chair is funded by LB Southwark
3. Additional costs for admin, additional and Process Manager are funded by LB Lambeth and LB Southwark.



Section 4: Requirements of the Child Death Review Statutory and Operational Guidance

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
1. BSCB newsletter? 2. The changes to CDOP have been discussed at BSCB meetings in Bromley and in CDOP/NDOP meetings for Southwark & Lambeth.
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*

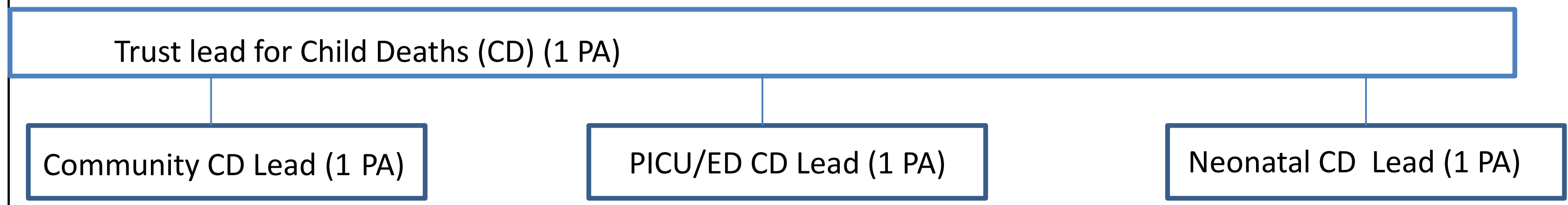
1. Kings (DH and PRUH sites) are planning a structure similar to that at the Evelina (add document)
2. GSTT (Evelina) has a structure and reporting process agreed and funded.

All hospital trusts in Bromley, Lambeth and Southwark already have bereavement midwives in post.

Child bereavement posts/Keyworker responsibilities to be added

3. In Bromley, the current Child Death Nurse role (0.2 WTE) will be extended to include the Key Worker/Process Manager role (0.5 WTE)

Proposed structure (to be finalised in July)



1. ECH lead for Child Deaths. 1 PA. Clinical oversight; evolution new review processes; liaison with adult settings for 17 & 18 year olds; report to Trust mortality board and external stakeholders including. CDOP; collation Annual Report; develop learning from child deaths; link to Director of Quality.
2. Community CD Lead. Role covered by existing Designated Doctors for Child Deaths (1.5 PAs each in Lambeth and Southwark, 1.2PAs in Bromley). Will cover deaths in the community, including hospices and other out-of-hospital settings.
3. PICU/ED CD lead. 1 PA. Cover all child deaths in PICU, (including all deaths of 17 and 18 year olds in adult ICU) and the Emergency Department. This role will also cover deaths in custody and deaths in in-patient mental health settings.
4. Neonatal CD lead. 1 PA. Cover all deaths in neonatal and maternity units.

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)*
If a child dies who is known to have learning difficulties (identified by the Designated Doctor), the Process Manager contacts the local LEDER lead and invites them to the relevant CDOP. Notification is by email.
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.*
The Designated Doctor role: • Decision to hold JAR will be in liaison with hospital paediatrician where child died in hospital (and Medical Examiner, if in post). • Will chair all JAR meetings • Will attend CDRM where chaired the JAR meeting for that child • Occasionally attend CDRM for neonatal death. • Chair CDRM for out of hospital deaths. There will not usually be a paediatrician available for home visit. The expected number of deaths requiring JAR in Bromley, Lambeth and Southwark each year is between 15-20.
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**

1. CDRM for children who die in hospital
The CDRM would be based on current Morbidity and Mortality meetings but with a broader range of attendees. They should be chaired by hospital paediatrician. Designated Doctor to attend and chair CDRMs for out of hospital deaths and attend but not chair in hospital meetings where there is a JAR.
CDRM attendees could include: GP or practice nurse, Health Visitor, community health services, mental health services, police, LAS, CSC, school/early years setting, plus others dependent on case.
Parents contributions are fed in via the Key Worker or another professional.
The PICU/ED Child Death lead Paediatrician will chair the CDRM for all child deaths in PICU and the Emergency Department.
2. The Neonatal Child Death lead Paediatrician will chair the CDRM for all deaths in neonatal and maternity units. This will use the data from the PMRT.
3. The Designated Doctor for Child Deaths (Community Paediatric lead) will chair the CDRM for out of hospital deaths and all deaths of 17 and 18 year olds in adult ICU. This role will also cover deaths in custody and deaths in in-patient mental health settings unless the child is taken to hospital / PICU / A&E.
4. The JAR will usually be chaired by the Designated Doctor for Child Deaths.

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

An Annual Report will be produced by end May each year. It will be published on each LSCB website and the SEL CCG website.