**Changes to Child Death review processes – Working together 2018**

Revised Working Together to Safeguard Children (2018), include changes to child death review arrangements and responsibilities.

The Statutory guidance identifies that the responsibility for reviewing child deaths now lies with CCGs and Local Authorities as they have through new legislation, been identified as child death review partners.

Child death review partners have agreed locally, on how the child death review process will be both set up and funded in their area. The geographical and population ‘footprint’ of child death review partners have been locally agreed, and extend across Bedfordshire and Luton CCGs and the three Local Authority areas, to include Bedford Borough Local Authority, Central Bedfordshire Local Authority and Luton Local Authority.

This footprint has taken into account networks of NHS care, and agency and organisational boundaries in order to reflect the integrated care and social networks of the local area. This model covers a child population that typically reviews at least 60 child deaths per year.

Child death review partners have come together to develop clear plans outlining the administrative and logistical processes for these new review arrangements and these will primarily be modelled on the current Child Death Overview Panel framework.

Wider learning will be achieved by expanding the current footprint through learning on an Integrated Care System (ICS) basis for shared learning events.

Child death review partners currently have two designated doctors for child deaths (one for Bedfordshire and one for Luton), who will be members of the multi-agency panel to review the child deaths. The designated doctors for child deaths are senior paediatricians who will take a lead role in the review process.

A process already exists whereby the designated doctor for child deaths is notified of each child death and is sent relevant information via a dedicated Child Death Review Manager who is closely linked to the CCGs safeguarding teams.

The Multi-agency panel will continue be chaired by a Director of Public Health and CDOP Partners will publish regular reports on how effective the arrangements for child deaths have been in practice.

A review of Governance has been considered. Annual reports will continue to be shared at the local LSCB meetings. Consideration has been given to ensure close collaboration with the work of the Local Maternity Transformation Board (LMS).

*Child Death Review Statutory and Operational Guidance 2018*